Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHWEST DIAGNOSTIC CENTER
88 BRIGGS AVE SUITE 110
SAN ANTONIO TX 78224

Respondent Name
CITY OF SAN ANTONIO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0497-01

MFDR Date Received
October 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A position summary was not submitted."

Amount in Dispute: $1475.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The DWC date stamp indicates the dispute was received on October 18, 2012. Due to the fact there were twenty-nine days in February this is a total of 366 days from October 18, 2011. Therefore, the provider is not eligible for dispute resolution. In addition, the enclosed CMS 1500 indicates the initial MRI was performed on July 01, 2011. A reimbursement amount of $790.54 was issued to Gonzaba Medical Group under check #00564979 on August 3, 2011. Therefore, the repeat MRI of October 18, 20911 was correctly denied as pre-authorization was not requested."

Response Submitted by: Argus Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2011	73218 RT	$1475.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.600 defines the health care that requires preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits (EOB)
   - 197A – precertification/preauthorization/notification absent. Pre-authorization required under rule 134.600, but provider did not request.
   - 193/193E – original payment decision is being maintained
   - 18 – duplicate claim/service

Issue

1. Did the requestor timely file their request for MFDR?
2. Did the respondent support its denial reason that preauthorization was required but not obtained?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the service in dispute is October 18, 2011. The request for MFDR was received by the MFDR Section on October 18, 2012. Texas Government Code Section 311.005, GENERAL DEFINITIONS, defines a "year" as 12 consecutive months. 28 Texas Administrative Code §102.3 COMPUTATION OF TIME, (a)(1) states due dates and time periods under this Act shall be computed as follows: "…In counting a period of time measured by days, the first day is excluded and the last day is included." The Division concludes that the request for MFDR was timely filed; therefore, this request is eligible for review per applicable division rules and fee guidelines.
2. The respondent submitted documentation to support that an MRI to the right hand was performed on July 1, 2011. Therefore, the MRI to the right hand performed on October 18, 2011 was considered a repeat MRI. Applicable rule 28 Texas Administrative Code §134.600 (p) lists the non-emergency health care requiring preauthorization to include (8) unless otherwise specified in this subsection, a repeat individual diagnostic study (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline. The current Medical Fee Guideline reimbursement for CPT code 73218 is $790.54 calculated as follows:

   54.54 workers compensation conversion factor ÷ 33.9764 Medicare conversion factor x $492.48 participating amount = $790.54. The requestor did not submit documentation to support that preauthorization was requested or approved. The respondent's denial reason is supported and no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor's disputed was timely filed; however, the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

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Authorized Signature

Signature	Medical Fee Dispute Resolution	March 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.